Turning Leaf Chiropractic

Motor Vehicle Accident Info.

Name: ____ Date: _______________

Nature of Accident

Date of Accident: ______________________________________Time:_______________

Where were you: **a) Driver** **b) Front Passenger** **c) Rear Passenger** **d) Pedestrian**

What direction were you headed: **a) North** **b) South** **c) East** **d) West**

On what street?____

What direction was the other car headed: **a) North** **b) South** **c) East** **d) West**

Were your struck from: **a) Behind** **b) Front** **c) Left Side** **d) Right Side**

Were you knocked unconscious? **Yes** **No** Did you hit your head? **Yes** **No**

Did your airbag deploy? **Yes** **No** Were you wearing your seatbelt? **Yes** **No**

Were the police on the scene? **Yes** **No** Was a report filed? **Yes** **No**

Nature of Injury

Did you notice any symptoms immediately following the accident? **Yes** **No**

If yes what symptoms did you notice immediately? ________________________________

____

If no, when did you notice symptoms and what were they?___________________________

____

Were you taken to the hospital/urgent care following the accident? **Yes** **No**

If so, where? ________________________________ By Ambulance? **Yes** **No**

What type of treatment did you receive?____

Have you been treated by any other doctors for this injury or accident? **Yes** **No**

____

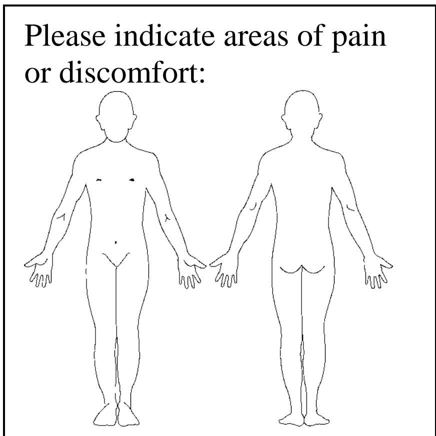
Since the injury, are your symptoms: **Getting Worse** **Getting Better** **Staying the Same**

Have you lost time from work? **Yes** **No** Date you Left: ________Returned?____________

Do you notice any activity restrictions as a result of this injury? **Yes** **No**

If yes, describe____

Please indicate areas of pain or discomfort:



What is currently your greatest area of pain or concern? ________________________________

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Please check Any/All symptoms noticed after the accident:

☐Headache	☐Dizziness	☐Light bothers eyes
☐Neck pain	☐Head seems heavy	☐Loss of memory
☐Neck stiffness	☐Ears ring	☐Face flushed
☐Pins & needles in arms	☐Pins & needles in legs	☐Buzzing in ears
☐Sleeping Problems	☐Numbness in fingers	☐Fainting
☐Back Pain	☐Numbness in toes	☐Loss of smell
☐Nervousness	☐Shortness of breath	☐Loss of taste
☐Tension	☐Fatigue	☐Loss of balance
☐Irritability	☐Depression	☐Stomach upset
☐Chest pain	☐Feet cold	☐ Hands cold
☐Diarrhea	☐Constipation	☐Fever
☐Cold sweats	☐Other:______________________	

Other pertinent information:____

____

____

Past History

Have you been involved in an accident in the past? **Yes No**

Describe: ____

Do you have any previous illnesses that relate to this case? **Yes No**

If yes, describe: ____

Automobile Insurance Information:

Have you contacted your insurance company? **Yes No**

Have you filled out an application for benefits? **Yes No**

Your insurance company:_______________________________________Phone:____________________

Adjuster(s) Name:____Phone:_________________________

Policy #__________________________________Claim #_______________________________________

Attorney Information:

Have you retained an attorney? **Yes No**

Attorneys' Name:____ Phone:_________________________

Firm Name:____

Address/City/State/Zip:____

Payment of Services

I clearly understand and agree that all services rendered to me are charged directly to me, and I am responsible for my account balance in the event that my auto insurance claim benefits are denied. I hereby authorize the doctor to release all information necessary to secure payment of benefits.
I authorize the use of this signature on any insurance submissions.

Signature:____Date:___________________